STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E210	A. BUILDING _____ B. WING _____	10/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW MANOR OF PEABODY	500 PEABODY PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of the health resurvey in the above named facility	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: The facility had a census of 51 residents. Based on observation record review and interview, the facility failed to promote care in a manner that maintains or enhances each resident's dignity for the residents who reside in the facility. Findings included: - On 10/09/12 at 2:35 PM, observation revealed Resident #13 requested yogurt from Nurse Aide E in the dining room. Nurse aide E walked into the south kitchen door and requested a yogurt from the dietary staff. A dietary staff was overheard responding to Nurse Aide E, "he/she can kiss my butt, I already gave him/her one". Nurse Aide E informed the resident the kitchen would get him/her one later. Further observation revealed Resident #13 left the dining room and walked down the hall. The Surveyor overheard the dialog while seated outside the South kitchen door. On 10/10/2012 at 9:04 AM, a nurse aide entered the North kitchen door and requested a fiber bar	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 241	Continued From page 1 for a resident. A dietary staff member was heard stating, " I'm not going to give her/him any damn fiber bars" to the nurse aide that stood outside of the door. The Surveyor over heard the dialog while seated in the "Quiet room" outside of the north kitchen door. On 10/15/2012 at 12:35 PM, Administrative Staff C verified all employees sign a form upon employment that stated they would not curse and would treat the residents with respect. Administrative Staff C verified the dietary member had not treated the residents with dignity and respect. The facility's policy, signed August 2009, stated the facility/staff would treat the resident with dignity and respect at all times. Continued review revealed demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist the resident as needed. The facility failed to promote dignity for the residents that reside at the facility as most reasonable people in our culture would find this experience to be very demeaning.	F 241		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		

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F 441	Continued From page 2 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: The facility had a census of 51 residents. The sample included 14 residents. Based on observation, interview and record review the facility failed to provide infection control practices in such a manner to prevent the development and transmission of disease and infection for the 51 residents who reside in the facility.	F 441		

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F 441	Continued From page 3 Findings included: - On 10/11/12 at 11:10 AM, observation revealed Dietary Staff F with an open skin lesion on the top of his/her right hand without it being covered with a bandage and/ or gloves. Continued observation during the food service revealed the staff taking off his/her gloves multiple times during meal service and attempting to serve food to the resident's without the skin lesion being covered. On 10/11/12 at 11:10 AM, Dietary Staff A verified the staff should wear gloves when preparing, handling and serving food to the residents when the staff has an open skin lesion. Review of the facility's undated policy, Personal Hygiene, instructed the staff to have any cuts, burns or skin wounds on hands, wrists and exposed portions of the arms to be covered with a bandage. The policy further instructed the staff to have the bandage covered with waterproof, single use gloves. - On 10/10/12 at 8:28 AM, observation revealed Nurse B administering an intramuscular injection to an unsampled resident. Observation further revealed Nurse B did not apply gloves before administering the injection to the resident. After Nurse B administered the injection, he/she touched the injection site without gloves on. On 10/15/12 at 10:03 AM, Nurse D verified the staff should wear gloves before administering an injection to the residents.	F 441		

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F 441	Continued From page 4 Review of the facility's April 2007 policy, Intramuscular Injections, instructed the staff to perform hand hygiene and put on gloves before starting to give an intramuscular injection. The policy further instructed the staff to slightly massage the site and then to remove the gloves. The facility failed to provide infection control practices for the 51 residents that reside in the facility.	F 441		